ATTENDING PHYSICIAN'S STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

State Form 17296 (R3 / 4-08)
Approved by State Board of Accounts, 2008

INDIANA STATE TEACHERS' RETIREMENT FUND
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This form must be delivered by the applicant to the attending physician. It must be made in the handwriting of the physician and mailed by him/her to the Teachers' Retirement Fund Board of Trustees. Applicant must make any payments necessary to complete this statement. This statement must be filed before a disability application will be considered.

PRIVACY NOTICE

Your Social Security number is requested by this agency in accordance with the requirements of IRS Code 3405. Disclosure is mandatory; this form will not be processed without this information.

This form is required as part of the application for a Classroom Disability benefit and is required for the annual review of the member's continued eligibility for the Classroom Disability benefit. The process for initiating or continuing a Classroom Disability benefit is:

1. **The "Attending Physician's Statement for a Classroom Disability Benefit" form must be completed by the member's personal physician.**
2. **After completion, the "Attending Physician's Statement for a Classroom Disability Benefit" form must be sent by the member's personal physician directly to the physician appointed by the Indiana State Teachers' Retirement Fund (Fund) Board of Trustees.**
3. **The physician appointed by the Fund will review the completed "Attending Physician's Statement for a Classroom Disability Benefit" form and make a determination as to the member's eligibility or continued eligibility for a Classroom Disability benefit.**
4. **The Fund-appointed physician will report his/her determination as to the member's eligibility or continued eligibility for the Classroom Disability benefit to the Fund.**
5. **The Fund will notify the member of his/her eligibility for a classroom disability benefit or of continued eligibility based on the recommendation of the Fund-appointed physician.**
6. **If the "Attending Physician's Statement for a Classroom Disability Benefit" form is being requested as part of the annual review for continuation of the Classroom Disability benefit, the final determination from the Fund-appointed physician must be received by the Fund within 60 days. If the final determination is not received within the required 60 days, the member's Classroom Disability benefit will be suspended until the final determination is received.**

Classroom Disability:
IC 5-10.4-5-1(b) A member who is an active teacher, has earned at least five (5) service credits, and suffers a temporary or permanent disability that continues for at least six (6) months may receive a classroom disability benefit for as long as the disability exists.
550 IAC 2-1-2.2 A classroom disability refers to a medically confirmed inability to continue classroom teaching due to a mental or physical condition that is not necessarily of sufficient severity to meet Social Security disability guidelines.
550 IAC 2-9-1(c) A member's continuing eligibility for classroom disability benefits shall be reviewed on an annual basis.

If, with reasonable accommodations made by the employer, the member is able to perform the essential elements of his/her job, he/she is not considered to be disabled from teaching and therefore does not qualify for a Classroom Disability benefit. As an example, the inability to drive to and from work is not justification for a disability determination if the member can otherwise perform the necessary teaching functions.

MEMBER INFORMATION			
Member name (*Last name, first name,middle name*)	**TRF number**	**Date of birth (*mm, dd, yy*)**	**Telephone number** ( ) -

I hereby make initial/renewal application for Classroom Disability benefits under the provisions of IC 5-10.4-5-1(b). I hereby authorize my physician to release such medical records as are necessary for this determination to the Fund-approved reviewing physician.

MEMBER AUTHORIZATION		
Signature of patient for the release of this information	**Printed name of patient**	**Date (*month, day, year*)**

PATIENT HISTORY (*to be completed by Attending Physician*)				
How long have you been the physician for the patient?		**Date of your first visit with patient for illness claimed to have brought about present condition:**		
Number of visits:	**Date of last visit:**	**Patient's height in inches:**	**Patient's weight in pounds:**	**Patient's Blood Pressure:**
What organ, system, or parts of the body have been affected?				
Describe fully the course of the disease—its initial symptoms and the history of its progress.				
Has the patient suffered from any ailments other than those mentioned above? If so, describe each case, and state the duration of the ailment and if recovery was complete:				
Has the patient been attended to or prescribed for by any other physician or surgeon within three years? If so, for what reason? Give names and addresses of all such physicians and surgeons:				
Is patient wholly and continuously unable to perform the work of a public school teacher?				
If so, is the disability, in your opinion, likely to be temporary; permanent and total; or permanent and partial?				
Please list specific reasons why you consider the patient to be unable to perform the work of a public school teacher:				
How long have you practiced as a physician and where did you receive your medical education?				
Signature of attending physician		**Printed name of attending physician**		**Date (*month, day, year*)**
Address of attending physician (*address must be printed and legible*)		**City**		
State	**ZIP code**	**Telephone number** ( ) -		

Upon completion, including the Attending Physician's signature, date signed, and printed name and address, forward this document to the physician appointed by the Fund's Board of Trustees. The physician's name and address are included in the cover letter accompanying this form.